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Introduction

Chairman DeWine, Senator Mikulski, distinguished Members of the Committee, thank you for inviting me here today to discuss the reauthorization of the Older Americans Act.

In the fortieth anniversary year of the Older Americans Act, it is appropriate to speak of the importance of this legislation to elderly people across the United States, especially those who are disabled and frail and at risk of institutionalization in nursing homes. The Older Americans Act has produced a wide array of programs to support the long-term care needs of elderly people. The Act brought federal support to meals-on-wheels, making it one of the most significant and worthwhile volunteer ventures in the history of this nation. The Older Americans Act brought consistency and quality to senior center programs across the country, providing declining seniors an opportunity to socialize with each other, to improve their nutritional status with healthy meals, and to see other aspects of their health status addressed through health screening, medication management, and physical activity programs. More recently, the Older Americans Act brought recognition and support to family caregivers, who to this day account for some two-thirds of all of the long-term care provided to elderly and disabled people across the U.S. In the 2000 reauthorization, the Act brought respite services to family caregivers, as well as information, access assistance, counseling, training and other supports.

We saw to the successful implementation of the provisions of the reauthorization of 2000 by focusing closely on the implementation of the caregiver program, where we brought vision, strategic planning, and performance accountability to the day to day management of the program. We also recognized the capacity of the aging network of States, area agencies, and service providers, which assist frail elderly people with long-term care services. As a result, we steered our discretionary innovation resources to pursuing program efficiency in long-term care, and improving the well being of elderly clients by focusing on prevention. Finally, we listened regularly to our consumers and those who serve them to ensure that we can move Older Americans Act programs forward in a way that will best serve elders, including the baby boom generation for years to come.

Older Americans Act Accomplishments Since Reauthorization in 2000

The National Family Caregiver Support Program

The single most important new provision of the 2000 reauthorization, and most significant accomplishment of AoA and the aging network since 2000, is the implementation of the National Family Caregiver Support Program. In the first two full years of the program's implementation, over 12 million people received information about the program, and many of these individuals have sought assistance through the aging network. At the time of the 2000 reauthorization, State and area agencies were projected to serve 250,000 caregivers with respite, access, counseling, training, or other forms of service. However, the number of caregivers served surpassed the projections so that States and area agencies provided access assistance services alone to almost 600,000 caregivers, and also provided respite, counseling, training, and other forms of support in 2003.

Soon after its initial implementation, the National Family Caregiver Support Program became a highly visible program that responded to the diversity of caregiver needs. At the same time, it forged connections to the home and community-based services (HCBS) system in each State. With AoA's emphasis on performance accountability and management, it became evident that resources provided under the caregiver program would not be the sole source of support for caregivers, but that Older Americans Act services provided to elderly people would also ease caregiver burden and help them care longer for the elderly they served.

AoA provided flexibility in program structure and operations that has allowed States to focus on such issues as developing new infrastructures for caregiver support; reorganizing State aging networks to be better able to integrate the NFCSP; and developing partnerships with entities not traditionally part of the State's aging network. As a result of this flexibility, States have reported a number of efforts focused on integrating the NFCSP into the existing HCBS infrastructure. Some approaches involved blending the NFCSP with other existing services, while others incorporated the program in a way that allowed it to stand on its own as a unique program yet still connected to the broader array of HCBS.

Ohio, for example, has approached integrating the FCSP by broadening its State care coordination policy to include many of Ohio's federal and State-funded programs for older adults and caregivers. This new framework fosters awareness of the similarities among programs and draws attention to the under-served and unidentified caregivers in other programs. As the FCSP becomes integrated into the continuum of care already in place, a more seamless approach to service provision will result.

Minnesota has utilized the development of the NFCSP to encourage AAAs, counties, providers and community organizations to examine other programs (Medicaid waiver, State respite programs, community service grants) to ensure that the NFCSP and HCBS programs offer a complementary array of services.

Georgia, in collaboration with the Rosalynn Carter Institute for Human Development (RCI), has utilized demonstration grants available through the NFCSP to expand a collaborative network of professional and family caregiver groups known as Care-Nets. Composed of educational institutions, businesses, and family caregivers, Care-Nets develop service and educational programs to meet the needs of caregivers, oversee research conducted by RCI, and provide recognition and support for caregivers.

Pennsylvania saw the NFCSP as a vehicle for expanding the scope of the existing State-funded caregiver support program and maximizing opportunities to get consumers into, and help them to navigate through, the long-term care system.

Coordination of the FCSP and other HCBS programs has been a key to assuring access and reaching caregivers, as was developing partnerships with business, religious, ethnic, social service and community organizations. States reported similar ways of ensuring that their FCSPs are accessible to anyone seeking information and services, including:

Alabama's "care coordinators" have taken a grassroots approach to doing outreach. Because a majority of the care coordinators have some direct experience with caregiving (either in the past

or currently), they are able to understand caregivers' needs and use their personal experiences with caregiving as a tool for outreach and education.

Alabama, California, Delaware, and Massachusetts have all utilized the concept of a "*mobile van tour*" to reach remote, hard-to-access areas of their States where caregivers have little opportunity to receive information, or because of the remote location, have difficulty getting to a central point such as a service center to obtain information and service.

Maryland has adopted a proactive strategy of reaching out to caregivers early, before they are in crisis. To achieve this, printed materials (e.g., bookmarks) have been printed and disseminated broadly to promote the program to a wide group of prospective consumers of caregiver services.

AoA commissioned the Family Caregiver Alliance to further document and summarize the States' efforts in implementing the caregiver program and to assess the States' performance in implementing the program. One interesting finding was that the vast majority (78 percent) of adults in the U.S. who receive long-term care at home, are cared for exclusively from unpaid family and friends. Other findings included the following: 1) More than one in three (36 percent) States began providing support to caregivers of older people for the first time as a result of the implementation of the NFCSP; 2) All States now provide some explicit caregiver support services as a result of the NFCSP; 3) The NFCSP is emerging as a key program in the States for enhancing the scope of services to caregivers and as fuel for innovation; 4) The NFCSP seems to be speeding the adoption of consumer direction in family caregiving programs; 5) Respite care is the service category most commonly offered to caregivers and is available in all 50 States and DC; and 6) State legislatures, recognizing family caregivers' roles, are enacting laws to fund caregiver support services, expand family and medical leave, and include family caregiving in State long-term care efforts.

Throughout the nation, States and communities committed the necessary resources, attention and commitment to the implementation of the National Family Caregiver Support Program that allowed the program to achieve the early results AoA sought for the program. States and communities served far more caregivers than early projections indicated would be served; and

from the beginning, States and communities provided the full range of services to caregivers, such as respite, access, counseling, training and supplemental services. This accomplishment demonstrated the capacity, organization and skill of the aging network of federal, State and community entities to implement a major new program to serve the long-term care needs of elderly people and their caregivers in a short period of time.

Accomplishments in Strategic Management of Network Capacity

The reauthorization of the Older Americans Act in 2000 allowed the aging network to expand the reach and scope of support to the elderly. The Act also fostered a more strategic approach to program management, whereby the activities and initiatives AoA undertakes are determined by their ability to produce the goals AoA established for the program. For example, AoA's initiatives to integrate long-term care in communities are designed to improve the efficiency of the program. States and communities are responding to these initiatives, and have increased the number of elders served per million dollars of AoA funding by over 10 percent by 2003. AoA's emphasis on improving the health and nutritional status of elders through its meals programs and health promotion and disease prevention initiatives are expected to help Older Americans Act clients remain in the community. The fact that 86 percent of caregivers surveyed by AoA report that Older Americans Act services help them care longer for the elderly than they could without the services, indicates that States and communities are succeeding in maintaining the independence of vulnerable elderly clients. Since the reauthorization of the Older Americans Act in 2000, AoA has employed a mission-driven strategic plan and performance outcome measures to demonstrate the effectiveness of its network of state and local entities, and we will continue to use these tools to pursue additional program improvements.

AoA program activities have a common purpose that reflects the primary legislative intent of the Older Americans Act: ***to make community-based services available to elders who are at risk of losing their independence, to prevent disease and disability through community-based activities, and to support the efforts of family caregivers***. This fundamental purpose is accompanied by the following four strategic priorities: 1) Make it easier for older people to access an integrated array of health and social supports; 2) Help older people stay active and

healthy; 3) Support families in their efforts to care for their loved ones at home and in the community; and 4) Ensure the rights of older people.

This new focus on strategic management was accompanied by a strong commitment to measuring performance outcomes, which in turn required immediate improvements in the data AoA used to measure performance. With the cooperation of state and area agencies on aging, AoA has achieved two significant improvements related to performance outcome data. The first was to improve the quality and to reduce the time lag in making program data available to support budget and other management decisions. Since 2000, AoA has reduced the time lag from 28 months to 11 months for the last budget cycle. AoA also instituted annual performance outcome measure surveys to obtain and use data reported by elderly individuals and caregivers about outcomes such as the usefulness and effects of Older Americans Act services and also about their satisfaction with the services they received.

This effort has resulted in comprehensive performance measures that have led to a new understanding of the nature and effects of Older Americans Act programs and the entities across the nation which administer services through these programs. We now measure the efficiency of Older Americans Act programs, and have documented significant efficiency improvements, noting again for our core programs an increase of 10 percent in the number of clients served per million dollars of AoA funding since 2001. We now measure our ability to target services to the most vulnerable of elderly individuals, noting again for our core programs that States and communities have increased the number of severely disabled clients who received selected in-home services by 15 percent over the FY 2003 base level for this measure. We now measure how consumers assess our core programs, noting that the percentage of caregivers who report that our services ***definitely*** help them provide care longer has increased to 68 percent, and that 82 percent of clients receiving transportation services rated the services as very good to excellent.

Our commitment to performance measures has guided and contributed significantly to: 1) our budget requests and initiatives over the past three years, which document how demonstration initiatives can contribute to improved performance in core programs; 2) our establishment of comprehensive performance partnerships with the Centers for Medicare and Medicaid Services

(CMS) and other HHS partners, which have allowed us to expand our demonstration initiatives beyond what AoA could support on its own; and 3) our proposals for the reauthorization of the Older Americans Act, which focus on modernizing the Act to better empower community-based organizations and consumers to contribute even more to helping elderly individuals retain their health, independence and dignity in the community.

Learning What Needs to Be Done in This Reauthorization

The upcoming reauthorization of the Older Americans Act provides an opportunity to build on the work of the current Older Americans Act. To guide us in identifying areas where the Older Americans Act can be improved, AoA has again used strategic management and performance results. Our commitment to improve the efficiency of our programs causes us to pursue greater integration of community-based long-term care services through the reauthorization of the Act. The lack of integration, which is often characterized by duplicative, uncoordinated programs and systems in the community, causes inefficiency in the delivery of long-term care in the community. Likewise, our commitment to help elderly individuals maintain their health and independence in the community, causes us to pursue through this reauthorization the expansion of the use of evidence-based health promotion and disease prevention programs and practices that delay and prevent the chronic conditions that are known to result in disability among the elderly.

Another significant source of information, which has guided AoA's activities over the past few years, is the numerous, grass-roots conversations we had with the elderly people and caregivers we serve and with those in the States and communities who serve them. The listening sessions we have conducted around the nation have presented us with a distinct opportunity to better serve our consumers and to more effectively implement our services in rural, urban, and suburban areas by listening to the concerns and challenges faced by older Americans and their caregivers. We have worked to ensure that we hear the voices of *all* of our consumers – including States, area agencies on aging, tribal organizations, service providers, volunteers, older persons and their caregivers, as well as, representatives of federal, State and local policy makers and the media. Nearly half of the comments received addressed ideas for future amendments to

the Act, and those ideas focused primarily on allowing greater flexibility in implementing the Older Americans Act, allowing greater integration of long-term care programs and funding streams to create a more seamless program of services for elderly people and caregivers.

Principles to Be Achieved with This Reauthorization

Perhaps the most significant contribution of the Older Americans Act over the past 40 years is the emergence of a long-term care service network, which is the largest provider of community-based long-term care for the elderly in the U.S. The State and area agencies on aging, and the service providers that comprise this network have grown to be the most significant source of community-based care under the major national programs serving the elderly, including Medicaid waiver programs. In addition to administering our Older Americans Act investment in long-term care, and related State and community-funded programs, this community-based long-term care network now administers and manages almost two-thirds of this nation's Medicaid investment in community-based long-term care for the elderly and disabled. Just as the Older Americans Act created this network that has provided so much in helping elderly people maintain their independence in the community, the Act should now be modernized to help this network and the country adapt to the challenges of sustaining community-based long-term care.

Demographic Issues

Many important changes are taking place in the elderly population, which are creating new challenges and opportunities for our society, families and individual citizens. The number of older Americans is increasing at unprecedented rates, and those Americans reaching age 65 are living longer than ever before. Among those over the age of 85, the proportion of people who are impaired and require long-term care is about 55 percent. While the precise number of people who will need long-term in the future could be affected by numerous variables, including possible declines in rates of impairment, the expected increase in the number of seniors as the baby boomers age is so great that most experts agree that there will be far more people in need of long term care in the future than there are today. By 2050, when all of the baby boomers will be age 85 and older, there will be over 86 million people age 65+ living in the United States, compared to 35 million today.

Primary Long-Term Care Issues

Three major issues in particular must be addressed in the modernization of the Older Americans Act: 1) the growing demand for long-term care; 2) the future public and private costs of long-term care; and 3) the systemic problems inherent in our current approach to financing and delivering long-term care services and supports.

Demand: The shift in our nation's demography that I cited above will have profound implications for every aspect of our society, and particularly for the future of long-term care. The projected demographic changes that are influencing the demand for long-term care will also affect how this care is provided. Families are expected to be smaller in the future than they are today, and if current trends continue, a greater proportion of women may be in the labor force. Both shrinking family size and increasing workforce participation by women could make informal care less available (women currently provide the majority of such care) and thus lead to a greater potential reliance on care from other sources. In addition, ethnic and racial minorities age 65 and over will grow faster than other segments of the population. By 2050, the African-American proportion of the elderly population will increase by more than half – from 8.2 to 12.0 percent – and the proportion of Hispanics among the elderly will almost triple from 6 to 16 percent. The issue of growing demand is directly linked with the baby boom generation. As the baby boom generation ages, the demand for long-term care services is certain to increase.

Cost: Even before the aging of the baby boom generation, the costs of long-term care are enormous. This year, $129 billion will be spent on older individuals receiving paid care – or approximately $15,000 per impaired senior. The major sources of financing are: Medicaid (39 percent); individual and private out-of-pocket expenses (36 percent); and Medicare (20 percent) which pays for some skilled nursing facility and skilled home health care.

It is important to note that another significant source of care is donated or non-paid care provided by families, friends and neighbors. Over 95 percent of all chronically disabled elders living in the community receive at least some unpaid family care, and two-thirds rely exclusively on such help. The dollar value of informal care is estimated to be $257 billion per year. As the

population ages and fiscal pressures on State budgets increase, it becomes increasingly important to find more effective ways to finance and deliver long-term care.

System Problems: While views may vary on exactly what we should do to prepare for the baby boom, everyone agrees that there are major problems with our current approach to long-term care, and our **system** of care needs fundamental reform. It is out of sync with people's needs and preferences. It is fragmented, confusing and inefficient. And it is financially unsustainable for individuals, families and our society at large.

Studies consistently show that seniors have an overwhelming preference to receive support at home. One recent study reports that 81 percent of persons over age 50 would prefer to avoid nursing home care even if they needed 24-hour care. Another study reports that 30 percent of older people would rather die than move to an institutional setting. While nursing home care is a critically important component of our support system, most experts agree we need to provide more opportunities for home and community-based services.

Another major problem with our current system is that it is fragmented, terribly confusing to consumers, and inefficient. Most people are simply unaware of their potential need for long-term care and their financial exposure to costs. Research shows that most Americans still equate long-term care with nursing homes and that many believe that Medicare pays for long-term care. When older people or their family members do seek out information or care, they face a complex, and often mind-boggling, maze of publicly supported and private options, administered by a wide variety of providers operating under different, sometimes conflicting – and often duplicative - rules and regulations. Consumers consistently report experiencing serious difficulty and frustration in trying to learn about and access available options. Compounding this situation is the fact that most individuals face difficult long-term care decisions amidst a **crisis**, such as an unexpected hospital admission (65 percent of nursing home admissions are directly from hospitals), or the collapse in a fragile unpaid caregiver support network. Under these circumstances, families have little time to explore the many options that might be available, and this often results in a nursing home admission or the unnecessary use of very expensive home health care.

Emerging Solutions

Just as the Older Americans Act has been the solution for so many significant policy challenges affecting frail elderly people in the past, and the caregiver program in particular in the recent past, we believe the Act is a very significant part of the nation's solution to the emerging long-term care financing challenges that we face now. And this solution will build on policies that the President and the Secretary of HHS have already instituted.

As evidenced by the New Freedom Initiative, the Administration is committed to creating a system of care that reflects the needs and preferences of Americans of all ages with disabilities, and the values of choice, control and independence. Since 2001, the Department of Health and Human Services, with the support of Congress, has provided the States and communities with a variety of new tools to help them advance the goals and values embedded in the New Freedom Initiative. These tools have included Medicaid demonstrations, including "Money Follows the Person" to fully fund one year of the cost of helping Medicaid nursing home residents return to the community; implementation of the National Family Caregiver Support Program; replication of the successful Cash and Counseling model; the Aging and Disability Resource Center Initiative; and the Own Your Future Campaign.

It is noteworthy that many of these tools also support the integration of people with disabilities into the workforce. As more people continue working past the nominal retirement age of 65, the provision of supports and accommodations will enable some individuals with disabilities to extend their employability well into their senior years. For seniors with disabilities, income from employment or self-employment will help improve their self-confidence and productivity as well as extend their independence and integration into their communities.

Several of the Administration's long-term care initiatives address the needs of the entire population. There are three strategies that are particularly relevant: empowering consumers to make informed decisions; targeting limited public resources to help high-risk individuals to stay out of nursing homes; and promoting the use of programs that can help older people reduce their risk of disease, disability and injury.

Empowering Consumers

Helping all individuals to make informed choices – including choices about their financing and care options – can enhance people's ability to stay at home and improve the quality of their lives. Increased awareness and use of two private financing options in particular would go a long way toward advancing these goals: private long-term care insurance and home equity programs. Both instruments are relatively new products and currently underutilized. Only about 4 percent of Americans aged 45 and older with incomes of at least $20,000 currently have long-term care insurance. In addition to giving people greater control over their future, long-term care insurance can reduce both Medicaid and Medicare costs.

One of the paradoxes of our current long-term care system is that impaired, older Americans are struggling to live at home at a time when they own more than $2 trillion in untapped housing equity. Over half of the net worth of seniors is currently illiquid in their homes and other real estate. Home equity instruments such as reverse mortgages enable older people to tap into the equity in their homes. It is estimated that 45 percent of households at financial risk for "spending-down" to Medicaid could take advantage of a reverse mortgage to help them pay for long-term care. On average, affected households could expect to get $62,800 from a reverse mortgage.

The Administration has launched two interrelated, complementary initiatives to empower people to make informed decisions about their financing and care options. One initiative, the *Own Your Future Campaign* was launched this past year to encourage more people to plan ahead for their long-term care. The project is a joint effort of the Administration on Aging, the Assistant Secretary for Planning and Evaluation (ASPE), the Centers for Medicare and Medicaid (CMS), the National Governors Association, and the National Conference of State Legislators. It is currently being piloted in five States (Arkansas, Idaho, Nevada, New Jersey, and Virginia), and involves the targeted mailing of HHS materials and a letter from the Governor of each State to every household headed by an individual between the ages of 50 and 70.

The Aging and Disability Resource Center (ADRC) Program, which was launched in 2003 by the Administration on Aging and the Centers for Medicare and Medicaid Services, is also designed to help people plan ahead for their long-term care, as well as address the immediate problems consumers face when they try to learn about and access needed care. This program provides competitive grants to States to assist them in developing and implementing coordinated access to information, individualized advice to consumers on their options, and streamlined eligibility determination for programs. The long-range vision is to have ADRCs serving as "visible and trusted" places at the community level nationwide where people of any age or income can go to get information on all available options. The program also reduces government fragmentation, duplication, and inefficiencies.

The Administration on Aging is also actively partnering with CMS to ensure that all older Americans take full advantage of the new prescription drug coverage available under the Medicare Modernization Act. This past year, we collaborated with CMS to inform seniors about the Medicare Drug Discount Card options and the transitional assistance program for low-income seniors. This AoA/CMS partnership provided almost $5 million in support to help community-based organizations assist low-income, limited-English speaking populations learn about and enroll in the transitional program. This year, we are working to help seniors to learn about and enroll in the Part D Program, including the low-income subsidy being made available through SSA. We have dedicated staff full time to this effort in both our headquarters and regional offices, and have assigned them to work on various CMS and SSA teams to oversee this national outreach and enrollment effort. AoA's goal is to enlist the active support of at least 10,000 of our community-based aging services provider organizations in helping older people learn about and take full advantage of the new coverage.

AoA is uniquely suited to add value to this partnership because it is inherent in our mission to provide access to information, resources, and services for older Americans. Our service providers can reach the homebound through home care and meals-on-wheels services. They can educate and advise senior beneficiaries who gather at senior centers and congregate programs. They can reach out to caregivers, who are known to help their frail family members make exactly the types of decisions that are needed for the drug benefit program. AoA's community-

based organizations are experienced providers of services to the poor, minorities, and those in rural areas. The network will service as it does in communities across this country as the tool to inform, educate and enroll. AoA's activities will be focused on getting information and support to these community organizations to ensure that they can and will participate in the education and enrollment of elderly people.

Targeting High-Risk Individuals

Another strategy is targeting limited amounts of public resources under capped appropriations to help individuals who are at high risk of nursing home placement to remain at home for as long as possible. These individuals are usually in a situation where they have neither the time nor the ability to do anything but use their liquid assets. The research shows that effectively targeting individuals who, without some form of help would have gone into a nursing home, is key to saving public dollars. Every day you help an individual stay out of a nursing home, you are helping them use their own personal and financial resources on less expensive forms of care for a longer period of time.

Seven States have implemented programs, all administered by their State aging offices in coordination with their regular Older Americans Act programs, and these are targeted explicitly at people who are at risk of nursing home placement. These States include Minnesota, Nebraska, New Jersey, New York, Rhode Island, Utah, and Wisconsin.

Building Prevention Into Long-Term Care

Most long-term care needs emerge from chronic diseases and other conditions, such as arthritis, diabetes, heart or lung disease, stroke and dementia, as well as from injuries suffered as a result of a fall or other accident. We now know these conditions and their effects can be mitigated, even for people who are very old, through life-style changes and disease management programs. Yet, our formal system of long-term care – like our acute care system - still emphasizes medical services over prevention. While changes are occurring in Medicare to give more emphasis to prevention and chronic care management, much more can be done through our public health and social service programs.

There is a growing body of scientific research, being generated by the National Institutes of Health, the Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality and others, documenting evidence-based programs that have proven effective in reducing the risk of disease, disability and injury among the elderly. Deploying these programs at the community level through venues, like senior centers and congregate meal programs, that can reach large numbers of older people when the opportunities for prevention are optimal (i.e., long before they become seriously disabled and/or spend down to Medicaid) can improve the quality of life and reduce health care costs.

One example is the Chronic Disease Self-Management Program (CDSMP), a model developed at Stanford University. This program is a six week workshop designed to empower people with various chronic diseases to take control of their health. The program has been shown to significantly improve participant health status and reduces the use of hospital care and physician services. Another example is a program developed at Yale University to prevent falls – a leading cause of serious injury and death among the elderly – and a major contributor to health costs. The Yale program uses a multifaceted approach to help older individuals cope with key risk factors. Participants are trained to improve balance, gait and posture, better manage their medication, and to remove home hazards. The program significantly reduces the incidence of falls among participants.

In an effort to begin bringing these types of programs "up to scale" nationwide, the Administration on Aging launched an Evidence-Based Prevention Program in 2003 in partnership with NIA, CDC, AHRQ, CMS and the John A. Hartford, Robert Wood Johnson, and several smaller foundations. The program is designed to demonstrate the efficacy of implementing evidence-based models at the community level through aging service provider organizations such as senior centers, nutrition programs, faith-based organizations, and senior housing projects. A dozen local projects are being funded for a three-year period. They focus on disease self-management, fall prevention, nutrition, physical activity, medication management, and depression. Each project is being evaluated to ensure that they maintain fidelity with the original research design and outcomes.

The employment of strategies such as these provide us a basis for hope that we can sustain our national support for the long-term care needs of the nation, even with the aging of the baby boom generation. The strategies focus on several principles that are simple but relevant: consumer information and choice; support for those at high-risk of disability and poverty before they are disabled and poor; prevention of conditions that cause disability and disease.

Reauthorization: The Opportunity for Policy Changes in Long-Term Care

The 2005 reauthorization of the Older Americans Act provides a unique and timely vehicle for accelerating the long-term care policy development that is needed to fully prepare the United States for the aging of the baby boom and the emergence of long-term living as a common experience of life. The Older Americans Act was passed in 1965 to promote the dignity and independence of older Americans and to help society prepare for an aging population. It was designed to complement two other programs enacted that year: Medicare and Medicaid. Congress charted out a vision in the OAA for a nationwide network of public and private agencies organized around the common purpose of promoting the development of a comprehensive and coordinated system of care designed to help older people live at home for as long as possible and avoid unnecessary placement in nursing homes.

The system envisioned in the OAA has become a consumer-driven, locally designed service program, supported by multiple funding streams, and capable of reaching people with low-cost social interventions long before they needed intensive services so that preventive opportunities could be optimized. The system was to be available to people of all income levels, and service resources were to be targeted at those most in need, especially low-income minority, isolated and limited-English speaking populations. Early reauthorizations of the Older Americans Act created area agencies on aging and fostered the principle of local flexibility and the use of a "bottom-up" planning process to ensure that OAA programs would reflect local needs and conditions. Over the last four decades, the Administration on Aging has guided the development of the national aging services network that today consists of 56 State units on aging, 655 area agencies on aging, almost 250 Tribal organizations, 29,000 community-based provider organizations, over 500,000 volunteers, and a wide variety of national non-profit organizations. This nationwide infrastructure currently provides a wide array of home and

community-based services to over 8 million elderly individuals each year, which is 17 percent of all people aged 60 and older, including 3 million individuals who require intensive services and meet the functional requirements for nursing home care. It also provides direct services to over 600,000 informal caregivers each year, who are struggling to keep their loved ones at home.

Many States have looked to their aging services networks to lead the development of their long-term care systems, including States that have created the most balanced and cost-efficient systems of care such as Oregon, Washington and Vermont. The OAA network is one of the largest providers of home and community-based care. It manages between $3 and $4 billion each year in public and private resources. All State units on aging have been given responsibility to administer State revenue programs; over 30 State units administer Medicaid Waiver Programs and State Health Insurance Counseling Programs; over 25 States have expanded the authority of the State aging units to serve younger populations with disabilities; and 22 States have authorized their State units to administer the Aging and Disability Resource Center program.

In short, the network created by the Older Americans Act and led by the Administration on Aging is positioned to help ensure the modernization of long-term care under the Older Americans Act. The network has experience in serving all populations. It has experience in serving the older population and those that are not elderly. It has served the caregivers of the elderly and disabled, and has reached out to these varied service populations with models of integration that can simplify access to services and provide choice to consumers. Community-based organizations across the nation have emerged as leaders in bringing evidence-based health promotion and disease prevention practices to the elderly in senior centers and in their homes.

The single most important goal of the Older Americans Act reauthorization should be to strengthen the Act so it can play a more central role in helping our nation prepare for the baby boom and long-term living. Consistent with Act's mission and the President's New Freedom Initiative, the reauthorization should reflect the values of consumer choice, control and independence, and the principle of providing care to people where they want it.

With the reauthorization of the Older Americans Act, AoA and HHS will propose forms of modernization along the lines that I have addressed here. We will pursue changes that will improve the efficiency and effectiveness of the largest long-term care provider network in the country. Prominent among those changes will be the integration of long-term care and efficiency in access to care by those who need it. We will pursue changes that recognize that we cannot wait until people are old and frail and poor to begin to address their long-term care needs. This will require that those who are not old should plan for their own long-term care. It will require the elderly who are not poor to make creative use of their existing resources to finance and support their care, with limited government assistance, to prevent poverty and the loss of independence. We will pursue changes that recognize the preferences of people for long-term care, which means a greater focus on community-based care and providing choice and control to consumers in the management of that care.

Thank you, Mr. Chairman, for the opportunity to speak to you today about the reauthorization of the Older Americans Act. I have tremendous respect for and confidence in the long-term network I have spoken about today. I am proud to have served as a community-based provider and a leader in this network for more than 30 of the 40 years that have passed since the Older Americans Act created it.